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ARMY MEDICAL EXPENSE AND PERFORMANCE REPORTING SYSTEM (MEPRS) NEWS BULLETIN

The Office of The Surgeon General, MEPRS Project Office, Falls Church, Virginia, and the U.S. Army Medical Command, MEPRS Division, Fort Sam Houston, Texas, publishes and distributes the Army MEPRS News Bulletin quarterly by fiscal year (FY) to MEPRS administrators worldwide. We have designed the Army MEPRS News Bulletin to enhance communication within the Army medical treatment facilities.

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SECTION I: TRISERVICE HAPPENINGS

REPORT TIMELINESS - The message is not getting through. Our overall reporting statistics are abysmal. If places like West Point and EAMC can report on time, there are no valid excuses for anyone. If you want respect you have got to earn it. Get the reports in on time. End of story.

EASIII/CHCS INTERFACE - The three Services are in the process of developing an interface between EASIII and CHCS. The Army requested this interface several years ago; however, it never materialized. Last Fall the Navy requested that an interface be developed between CHCS and their financial system, STARS/FL, and EASIII. The Navy was willing to finance this interface and also wrote the Functional Description (FD). After several meetings between the Services, we are almost at the Product Design Review (PDR) stage. To date, there have been three System Requirements Reviews where the Services defined their requirements. The data we, the Army, expect to receive from the interface is that which is a natural by-product of data entry to CHCS. For example, CHCS will feed the occupied bed days, visits, admissions, and dispositions on the respective SASs, eliminating the requirement for users to input into those SASs. CHCS will also pass to EASIII, weighted procedures from radiology, pathology, pharmacy, and respiratory/inhalation therapy. The data is collected in CHCS, compiled in the Worldwide Workload Report (MED302), then uploaded to EASIII. The projected implementation date for the CHCS/EASIII Interface is early 1996.

CPT CODES - Effective 1 October 1995, both EASIII and CHCS begin using CPT codes for Radiology and Pathology. This will only take place at the CONUS sites. You may remember that we attempted to implement CPT codes before, but encountered a licensing problem. This same problem still exists for the OCONUS sites who will continue to use the current procedure weights table. The Service representatives used the current procedure weights table and translated it to CPT codes hoping to make this effort a smooth transition.

DOD 6010.13-M - The Services are continuing their efforts in rewriting the 6010.13-M. We hope to have it published and to you by August of 1995. However, if there are any items you would like clarification on, please submit those to your analyst by

12 May 1995.

DEFINITION OF A VISIT - The following is the definition of a visit:

VISIT - Health care characterized by the professional examination and/or evaluation of a patient and the delivery or prescription of a care regimen.

a. Visit Criteria. The three following criteria must be met before a visit can be counted:

(1) There must be interaction between an authorized patient and an individually privileged health care provider or health care provider authorized in accordance with AR 40-48.

(2) Independent judgement about the patient's care must be used, assessment of the patient's condition must be made,
and any one or more of the following must be accomplished:

(a) Examination.

(b) Diagnosis.

(c) Counseling.

(d) Treatment.

(3) Documentation must be made in the patient's authorized record of medical treatment. Documentation must include at least the date, name of clinic, reason for visit, assessment of the patient, description of the interaction between the patient and the health care provider, disposition, and signature of the provider of care. (Repetitive clinic visits to specialty clinics; i.e., physical therapy and occupational therapy, will not require full documentation as stated above after the initial visit unless there is a change in the prescribed treatment. There must also be final documentation upon completion of prescribed treatment.) In all instances, a clear and acceptable audit trail must be maintained.

b. Classification. Classification of a visit meeting the

criteria of paragraph a, will not be dependent upon:

(1) Professional level of the person providing the service (i.e., physician, nurse, physicians assistant, medical technician/corpsman, or medical specialist).

(2) Physical location of the patient.

(3) Technique or methods of providing health care service (such as, telephonic or direct patient contact) when the criteria in paragraph a are met.

c. Types of Visits. The following types of visits are reportable when the criteria in paragraph a are met:

(1) Inpatient Visit. An inpatient visit will be counted for the following situations:

(a) Each time an inpatient is seen within the admitting MTF on a consultative basis in an outpatient clinic or in the physical examination and standards section for evaluation of profile changes.

(b) Each time contact is made by clinic or specialty service members (other than the health care providers from the treating clinic or specialty service) with patients on hospital units/wards, when such services are scheduled through the respective clinic or specialty service; for example, a physical therapist being requested by the attending health care provider to initiate certain therapy regimens to a patient who is in traction and unable to go to the clinic. Conversely, a routine ward round made by a physical therapist or dietitian will not be countable as a visit. (See paragraph d(2) for the handling of all ward/grand rounds.)

(2) Outpatient Visit. An outpatient visit can be counted for the following situations:

(a) All visits meeting the criteria in paragraph a to a separately organized clinic, or specialty service made by patients who have not been admitted to the reporting MTF as an inpatient.

(b) Each time medical advice or consultation is provided to the patient by telephone, if the criteria in

paragraph a are met.

(c) Each time a patient's treatment/evaluation results in an admission and is not part of the preadmission or admission process.

(d) Each time all or part of a complete or flight physical examination, regardless of the type, is performed in a separately organized clinic or specialty service. Under this rule, a complete physical examination requiring the patient to be examined or evaluated in four different clinics is reported as a visit in each of the four clinics. For the handling of other types of examinations, see paragraph d(1).

(e) Each time an examination, evaluation, or treatment is provided through an MTF-sanctioned health care program in the home, school, work site, community center, or other location outside of a Department of Defense (DOD) MTF by a health care provider paid from appropriated funds.

(f) Each time one of the following tasks is performed when not a part of routine medical care; when the visit is associated with or related to the treatment of a patient for a specific condition requiring follow-up to a physical examination; and when the medical record is properly documented in accordance with the criteria of paragraph a:

1 Therapeutic or desensitization injections.

2 Cancer detection tests (e.g., PAP Smear).

3 Blood pressure measurements.

4 Weight measurements.

5 Prescription renewals (not including refills).

(3) Multiple Visits (inpatient or outpatient).

(a) Multiclinic Visits. Multiple visits may be counted if a patient is provided care in different clinics or is referred from one care provider to another care provider for consultation on SF 513; for example, a patient seen at the primary care clinic and at two other specialty clinics on the

same day can be counted as three visits; a patient visiting a clinic in the morning and again in the afternoon can be reported as two visits. However, to count two visits the first visit must be completed; for example, the patient must have been evaluated, treated, and dispositioned, and the required documentation made in the medical records. Only one visit can be counted if the visit in the afternoon is merely a continuation of the visit in the morning; for example, a patient seen in the orthopedic clinic in the morning is sent to radiology for x-rays, and returns to the orthopedic clinic in the afternoon for continued evaluation or treatment. These rules apply even if the patient is admitted to an inpatient status immediately following a clinic visit. Also, two visits can be counted when an occupational or physical therapist provides primary care (patient assessment while serving in a physician extender role) and subsequently refers the patient for specialized treatment in the same clinic on the same day.

(b) Group Visits. Only the primary provider of group sessions may count one visit per patient if the criteria in
paragraph a are met.

(c) Multiprovider Visits. When a patient is seen by
more than one health care provider in the same clinic for the same episode of care, only one visit is counted per patient. If a second opinion is requested by the patient, a visit can be counted provided the criteria in paragraph a are met.

(d) Services Not Reportable as Visits.

1 Occasion of Service. Without an assessment of the patient's condition or the exercise of independent judgement as to the patient's care, screening examinations, procedures, or tests are classified as an "occasion of service," because they do not meet the criteria of paragraph a above.

2 Ward Rounds/Grand Rounds. Ward rounds and grand rounds are considered part of the inpatient care regimen and are not counted as inpatient visits. Visits by an inpatient to an outpatient clinic for the convenience of the provider, and in lieu of ward or grand rounds, will not be counted.

3 Group education and information sessions that do not meet the criteria in paragraph a.

4 Care rendered by providers paid from nonappropriated funds.

SECTION II: ITEMS OF INTEREST

FAREWELL - MAJ Shaw, who has been our Division Chief for the last four years, will soon jump off the MEPRS train. He is headed for Heidelberg, Germany in June 1995. MAJ Shaw's knowledge, commitment, and support of MEPRS has become invaluable to all of us. Although he's not gone yet, those of us who have worked with him, think of him as our "mentor" and are realizing how much we will miss his foresight and enthusiasm, but most of all his genuine concern for his "MEPRS Family".

CC:MAIL - Doris Walters, Secretary, MEPRS Division, MEDCOM, created a Private Mailing List in cc:Mail from the names that are on the MEPRS Contacts Listing. If you are in the cc:Mail directory, you will receive this newsletter through cc:Mail. If you are not in the cc:Mail directory, the newsletter will be sent in the normal manner, which is to the MPO address through Internet-Mail. When cc:Mail becomes available at your facility and your name is added to the cc:Mail directory, send Doris a cc:Mail.

MEPRS CONTACTS LISTING - Please note the following changes to the MEPRS Contacts Listing:

a. Fort Drum has a new fax number. It is DSN 341-6988 or Commercial (315) 772-6988. The old fax number is still active and should be used if, for some reason, they can not be reached at the new number.

b. Fort Leavenworth has a new fax number. It is DSN 552-6610 or Commercial (913) 684-6610.

c. Fort Huachuca's new commercial area code is (520).

d. Redstone Arsenal has a new point of contact, Chieko Hernandez.

e. Fort Huachuca has two additional points of contact, Mike Christopher and Tish Nealy.

If you have any changes to the MEPRS Contacts Listing, please notify Doris. She will publish any corrections/changes to the list in this section of future issues of the MEPRS News Bulletin.

MEDICAL HEALTH CARE MANAGEMENT INFORMATION SYSTEM (MHCMIS) INTERFACE - Health Affairs is slowly resolving the problems experienced with the MHCMIS interface. The last problem we are experiencing is invalid DRGs. The DRG file from MHCMIS will not upload into EASIII if it contains invalid DRGs. Health Affairs is aware of this problem and working diligently in trying to resolve it.

When the requirement of 90 percent record completion is met, the DRG file will be passed to EASIII. MEPRS personnel will be able to upload the DRG file on a quarterly basis. EASIII 7.1 release must be loaded first. The instructions start on page 10-197, para 10.4 of the EASIII User's Manual.

After the DRG calculations have been completed, the DRG files will be included when MEPRS files are transmitted to Service Agency. Every site that has MHCMIS will transmit the same files to MHCMIS as they do to Service Agency each month. There is an address for MHCMIS in your transmission table. This is regardless of whether or not the DRG calculations have been performed. If you are experiencing any other problems, please contact your MEPRS analyst.

VETCOM AND DENCOM TDA - Effective with the 0195 TDA, the VETCOM and DENCOM began reporting separate TDAs and UICs. Due to this change, there has been some misunderstanding about who is responsible for TDA maintenance. After several meetings with our MEDCOM Manpower Division, it was agreed MTF staff will continue support of these activities as stated in the HSC Reg 10-1. Staffing for this function remains in the Manpower Office. Maintenance of the TDA will continue to be a function and responsibility of the Manpower Division, whether it is the MTF, Dental or Veterinary TDA.

In order to accommodate the separate TDA's, UCAPERS will provide the capability to distinguish between MTF, DENTAC, VET TDA's. The actual method has not been completely worked out as yet; however, the preliminary plan is to utilize a field on the TDA to identify paragraph 100 for the MEDDAC from para 100 for

the DENTAC and para 100 for VET activity. The software change will be implemented prior to October 1995.

SECTION III: UNIFORM CHART OF ACCOUNTS PERSONNEL UTILIZATION SYSTEM (UCAPERS)

Updates have been made to the Clinician/APN Utilization, the majority of the changes are in regard to how the hours are mapped. This software release will be transmitted this month.

SECTION IV: EXPENSE ASSIGNMENT SYSTEM VERSION III (EASIII)

EASIII 7.1 Release - The 7.1 software release was transferred to your facility on 25 April. Upon receipt of the release, we requested you load the release within 5 working days. To date, there are only a few sites that have notified the Customer Support Help Desk that they are ready to load the release. Although, there are no time constraints in doing so, we request you notify the help desk as soon as possible. The 7.1 release notes along with change pages to the EASIII User's Manual were also mailed on 25 Apr 95. If you do not receive the documentation by the 5 May 95, please notify your MEPRS analyst.

FOURTH LEVEL MEPRS CODES - We are in the process of updating our Fourth Level MEPRS Codes; however, we are reiterating the following list of fourth level MEPRS codes we have assigned over the last year:

GDAC - Haiti
GDAD - Rwanda
GDAE - Cuba
FAZO - Open Allotment
FEBY - Travel for Desert Storm Patients

FCDH - HSSA Support
FCDL - Lead Agent Support
BHGY - Desert Storm Clinic
BDAC - Early Intervention Program

SECTION V: BACK-UPS

SYSTEM BACK-UPS - Two of our facilities have submitted system change requests (SCRs) in regards to the time limit when performing system back-ups. You are only given five minutes to answer the prompt to load the second tape. If the prompt times out, the back-up procedures restart from the beginning. We submitted the SCRs with the recommended resolution of combining the total system back-ups with the initialization process and also in the case of a time-out, have the back-up process restart from the point of the time out, not from the beginning of the back-up process.